Tax-Supported Medical Care for California's Children

Where Should It Be Going?

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• **The multiplication of separate governmental agencies providing health services to California's children, the increasing difficulties in staffing tax-supported health agencies and the recent studies of the quality of care under these programs, have all pointed to an urgent need for prompt decisions on certain basic questions about the function of tax-supported medical care for children of dependent families.**

Fourteen separate kinds of health services are currently provided through public funds at an annual cost to California taxpayers of $52,000,000. These funds underwrite an uncoordinated, fragmented, patchwork quilt of medical care for some 500,000 children. Coordination and integration of these services through "one door" with uniform eligibility requirements and maximum utilization of private physicians' services that meet appropriate standards is needed now. California physicians have an urgent responsibility to provide leadership in the development of more effective and more economical organization and distribution of higher quality medical care services for California's children dependent on public support.

RECENT EVENTS in California have dramatized how urgent the need is to face and decide certain basic questions about the future of tax-supported medical care for children now.

These questions turn upon a thesis that can be summed up as follows:

1. There is general agreement that today in California our goal is to make available comprehensive medical care of high quality to all children.

2. Among all children special attention is given to those whose families, because of economic circumstances, cannot themselves afford to pay the costs of medical care. They now rely in part or in full upon tax funds for such care and will continue to in the foreseeable future.

3. Medical care for California's children provided from tax funds today is a confusing, fragmented jumble involving many agencies. Nowhere is it comprehensive and rarely is there reasonable consistency or coordination among the fragments.

4. Looking forward in California to many more children, relatively fewer health personnel and increasingly complex and costly medical care, we must move quickly toward rational and effective organization based upon the "one-door"[1] principle and upon maximum utilization by tax-supported programs of private health personnel and facilities that meet necessary standards.

Point One needs no further amplification. Comprehensive health care of high quality is now considered a basic human right and society through many media, including government, is moving to make it readily available to every one, especially the young and the old.

The role of government in the provision of medical care to special groups of children does need elaboration since these facts are neither easily obtained nor widely known. Table 1 lists the principal tax-supported medical care programs for persons under 18 years of age in California, showing the agencies administering them, the kinds of service provided, the kinds of children eligible, the number of children served each year and the annual amount and sources of tax dollars. It includes 14 kinds of health service provided to over half a million California children a year by at least seven different "patient-contact" agencies at an annual cost in federal, state and local taxes of more than $52,000,000. This represents about 20 per cent of the cost of all personal health services for all California children.

Most of these services have been tax-supported for a long time and have not increased relative to population during the last ten years. For example (Chart 1) the per cent of infants born in county hospitals has remained constant at close to 12, the per cent of infants seen at least once in child health conferences has remained constant at close to 20, and the per cent of children under 21 receiving Crippled Children's Services has remained constant at close to 1. However, three significant new programs now costing over $9,000,000 a year were born in the last five years—Public Assistance Medical Care (wel-

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TABLE 1.—*Principal Tax-Supported Medical Care for Children (Under 18), California, 1959*

Agency	Services: Kinds	Services: Provided By	Eligible Group	No. of Persons Served	Estimated Cost: Million $	Estimated Cost: Tax Sources
Local Adm.—						
County hospital	Newborn	Pub.	Med. indigent	44,724	2.	County
	Premature	Pub.	Med. indigent	4,756	1.4	County
	Pediatric—In pt.	Pub.	Med. indigent	36,000	11.0	County
	Pediatric—Out pt.	Pub.	Med. indigent	?	1.9	County
Health	Child clinics	Pub.	Public, age specific	188,842	1.0	Local-State-Fed.
	Home visits	Pub.	Public	129,844	.5	Local-State-Fed.
	CCS	F/S	Med. indigent	58,042*	6.6	County-State-Fed.
Mental health	Psychiatric	Mixed	Med. indigent	?	1.3	County-State
Public schools	Preventive	Pub.	Public school children	?	10.0	Local-State
Welfare	Home and office	F/S	Aid-to-Needy-Children	200,000	6.0	State-Fed.
State Adm.—						
Mental hygiene	Hospitals for retarded	Pub.	Severely retarded	4,886**	10.0	State
Federal Adm.—						
Defense	Medicare	F/S	Military dependents	35,000 births	1.7	Federal
	Mil. bases:					
	Newborn	Pub.		11,134	0.8	Federal
	Pediatric	Pub.		?	3.0	Federal

Key to Abbreviations: CCS=Crippled Children's Service; Pub.= Public Facility and/or Staff; F/S = Fee for Service; *to 21 years; **under 20 years.

fare), Community Mental Health (Short-Doyle) and Military Dependents' "Medicare."

Let's look next at the existing pattern of children's medical care provided by our tax dollars. Are these monies being spent in a coordinated, logical, economical way, as we have a right to expect? The answer is, definitely, no.

We will limit our discussion here to medical care for children who are socially and economically at a disadvantage. We do not take issue with the provision of comprehensive care of high quality by the Federal Government to children of fathers in military service except to urge that it be made really comprehensive and that where it is to be provided outside of military facilities, it be well planned in advance with the states, regions and communities involved.

The outstanding characteristic of our present patchwork quilt of public medical care for children is uncoordinated fragmentation. Almost the only characteristic these programs have in common is their financing from tax funds, and even this disappears when one looks at the sources of taxes. We would be hard put to design an administrative arrangement which made it more difficult to provide comprehensive care of any quality. Eligibility is identical in no two programs. It is understandable that health department staffs and practicing physicians have difficulty figuring out the rules for admission. What is amazing is that any low income family can produce the necessary combinations of age, economic status, geographic residence and appropriate state of health or disease, at the proper place and time, to obtain care for its children. In front of the very groups who are least motivated by past experience and pressure of other problems to seek early medical care, we place the most obstacles.

It is easy and for some purposes enough for us to look at this fragmentation from our professional and administrative viewpoints. We have been trying also to look at it from the more important viewpoint of the families being served, or not served. Take, for instance, families on the Aid-to-Needy Children's (ANC) program in Santa Clara County. A 4 per cent sample of all ANC families in that county was interviewed at home during the summer of 1959 as one of a series of studies on tax-supported medical care for children there.

Three hundred and seventy-four persons under age 18 lived in these families but because of remarriages 18 per cent were not receiving ANC. These families were by definition atypical of Santa Clara County families. Not only were they all near the bottom of the economic ladder, but they tended to include large numbers of children, to have only one parent, to be of Mexican background, to move frequently, and to live in poor housing.

There can be no question that these children were poorly protected by preventive health services. One-third of the families had never had a physician

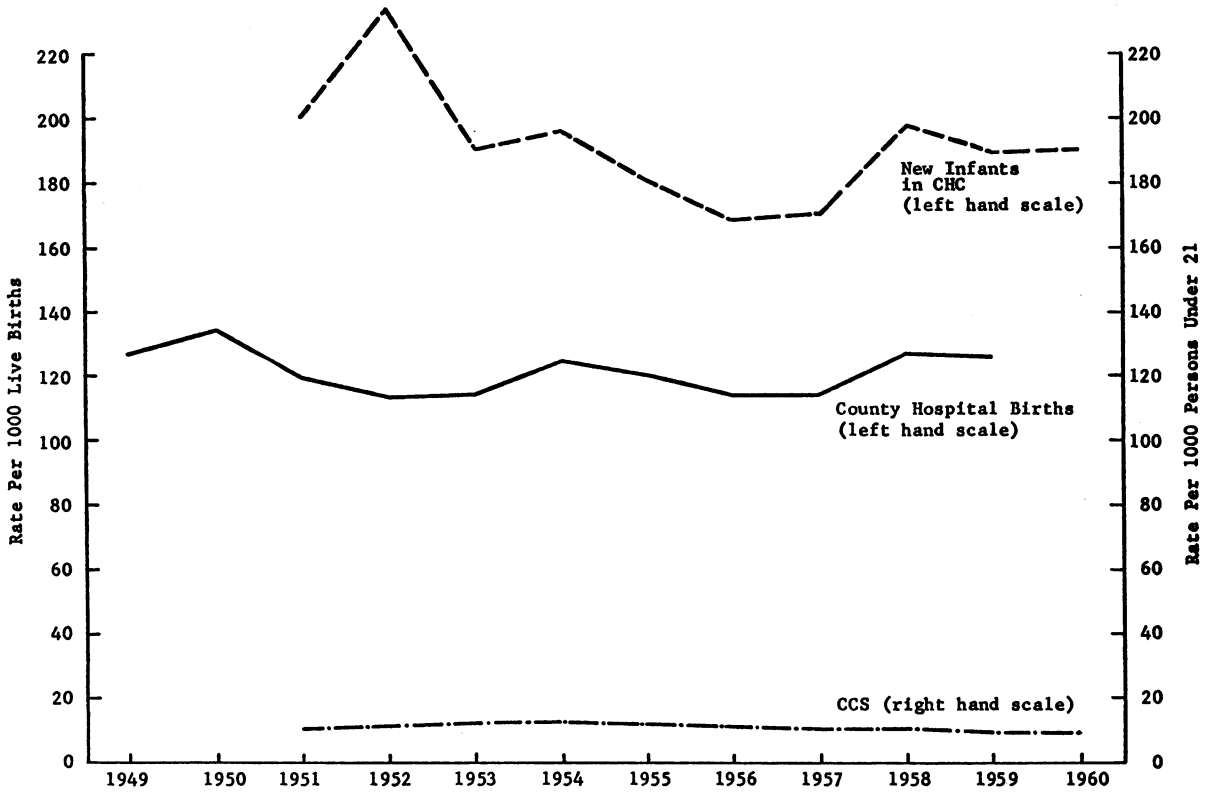

Chart 1.—County Hospital Births, Child Health Conference (CHC) Services and Crippled Children Services (CCS) California, 1949-1960.

check-up for any well child since birth. One-half of the families had never had dental care for any child. Almost two-thirds of the children had not had a check-up by a physician in the previous year and three-quarters had not visited a dentist in that time. Sixty per cent of the school children were not adequately protected against poliomyelitis. Three-fourths of the mothers with children under three years of age had not received any prenatal care in the first trimester of their latest pregnancy.

The families were also asked about the sources of medical care actually utilized by them for illnesses or injuries they recalled during the preceding year, and about problems encountered in obtaining care. Almost half of the medical contacts were with private physicians; one-quarter with the county hospital, and about one-eighth with the health department. Some private care was financed directly by the families themselves and not by tax-supported programs. The problem of trying to figure out which source of care to go to with a particular child with a particular illness appeared to be a real one for many of these families. By and large, they were able to figure out how to obtain care for acute conditions, but tended to have serious problems in obtaining adequate care for chronic illnesses and handicaps. Fragmentation appears to be a problem for parents, too.

Anyone looking at our present tax-supported programs of medical care for children cannot help asking why one-third of those tax dollars provides care by using, at cost, private facilities and staff in the community, while the other two-thirds finances separate government facilities and staff. It is hard to make a case in this day and age for separate tax-supported facilities and staff except possibly for certain expensive types of care such as rehabilitation, long-term in-patient care, or special home care for which private resources remain lacking. Separate services usually require expensive widespread duplication of private services if they are really to be available to people and inherently tend to provide a lower standard of care than exists for the community in general. This stems in part from a reluctance to pay, in tax dollars, the cost of good medical care for poor people. The reluctance comes from the attitude that taxes are bad and that poor people won't use good care properly anyhow. The problem is dramatized in the difficulties of adequately staffing county hospitals with physicians and nurses.

From a reading of the daily newspapers in Madera, Sutter, Imperial and Yolo Counties in recent months, we cannot escape being deeply concerned with the increasing difficulty encountered in obtaining qualified physicians and nurses to serve in these county hospitals. In Madera, where more than a

third of the deliveries in the entire county takes place in the county hospital, the four-physician staff dwindled to zero. That hospital operated on a stop-gap emergency arrangement, using resident physicians of neighboring county hospitals. Sutter County was also faced with the departure of both members of its physician staff. Imperial County Hospital staffing problems have received wide notice, as did Yolo's previously.

There are, of course, other problems and issues in the provision of tax-supported medical care for children. We have singled out *fragmentation, availability* and *double standards* only as prime examples requiring action now if we want our public medical care programs in California to close the wide gap between them and our remarkable progress in scientific medicine.

Where should we be going? The Governor's Committee on the Study of Medical Aid and Health stated clearly in December of 1960 what we believe to be essential to end fragmentation: "Coordination and integration of health services through 'one door,' i.e., a single local agency where services may be obtained or from which persons may be referred for appropriate care." This encompasses a need to achieve uniform eligibility requirements in various programs and to integrate them functionally at the point where people are served so that they provide comprehensive care instead of the current patchwork. We have already indicated that in our opinion it requires elimination of separate government facilities and staff and maximum utilization at cost of private services that meet appropriate standards. It requires development of a central mechanism for exchange of medical information among the various programs and central assignment of specific responsibility for assuring continuity of care for each individual served. There is need for federal and state legislative and administrative changes to make it easier to accomplish better coordination locally. There is need particularly among low income families to recognize and provide for the close interdependence of health with many other economic, social and cultural problems.

Above all there is need at all levels, public and private, for leadership in reaching these ends. The urgent need for "one door" is patent. Where the door is to be and how well it will work are vital questions for all of us as physicians. But let's be blunt and not pretend that this patchwork is a popular subject for discussion and action. Actual examinations and reports of the quality of tax-supported medical services are not popular in 1961. There are real blocks in the way to improvement. Among the most serious are: (1) improved medical care for indigents will cost more and raise taxes; and (2) fear and misunderstanding on the part of some segments of leadership in organized medicine which lead to an attitude that participation in tax-supported medical programs for indigent families is inappropriate.

The important point is that *change is occurring* rapidly and that now is the time when physicians must exert themselves to see that change produces *better* medical care for children. Physicians are used to the experimental approach to better prevention and treatment of disease. They need now to extend their skills to the experimental approach to better organization and distribution of medical care. The present patchwork is demonstrably no bargain. California medicine can and must do better.

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REFERENCE

1. Governor's Committee on the Study of Medical Aid and Health: Health Care for California. State Department of Public Health, Berkeley, California. December 1960.